

to do the job, but lacked the authority to do so before the passage of the Police Coordination Act.

Agencies have already signed agreements with the U.S. Attorney for the District of Columbia enabling them to participate. Federal agencies understand that the extension of their jurisdiction will enhance safety and security within and around their agencies while offering needed assistance as well to District residents. The Capitol Police and Amtrak Police, who have the longest experience with expanded jurisdiction, report that the morale of their officers was affected positively because of the satisfaction that comes from being integrated into efforts to reduce and prevent crime in and around their agencies and in the nation's capital. This non-controversial technical amendment to the Police Coordination Act is another step to achieving my goal of assuring the most efficient use of all the available police resources to protect federal agency staff, visitors and D.C. residents.

#### INTRODUCTION OF THE ALL-PAYER GRADUATE MEDICAL EDUCATION ACT OF 2001

**HON. BENJAMIN L. CARDIN**

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

*Thursday, June 14, 2001*

Mr. CARDIN. Mr. Speaker, I rise today to introduce legislation that is vital to the future of our nation's health care system. America's academic medical centers and their affiliated hospitals are essential to the nation's health. These centers do much more than train each new generation of health professionals. Every American benefits from advances in medical research and well-trained providers. Medical advances have dramatically improved the quality of life for millions of Americans, and our academic medical centers are at the heart of the new era of biotechnology, which holds the promise of effective treatments for so many diseases.

Although academic medical centers constitute only two percent of our nation's non-federal community hospital beds, they conduct 42% of all health research and development in the United States, they contain 33% of all trauma units and 31% of all AIDS units, and they treat a disproportionate share of the country's indigent patients. However, funding for these critical tasks is at risk in the new competitive health care marketplace. Commercial insurers are displaying increasing reluctance to pay academic medical centers adequately to support their educational and research missions, and managed care companies steer patients away from these centers as well. Generally, managed care companies cut costs by seeking the lowest cost hospitals and physicians. An academic medical center cannot compete if forced to cover part of its teaching costs through the rates that it charges for medical services. Without a separate funding source for academic costs, these centers run the risk of being non-competitive for managed care contracts through no fault of their own.

Two years ago, The National Bipartisan Commission on the Future of Medicare studied graduate medical education funding and proposed eliminating Medicare's funding role

and moving GME into the general appropriations process. It was an approach that would have seriously undermined not only academic medical centers, but also the future of the medical profession. Fortunately, this recommendation was not enacted.

There is a better way, a much fairer way, to provide for graduate medical education, while ensuring the health of the Medicare Trust Fund. To ensure stability of funding for GME in the increasingly turbulent health economic climate, continued predictable support from Medicare is essential. But even Medicare's contribution does not fully cover the costs of residents' salaries, and more importantly, our current funding system fails to recognize that a well-trained physician workforce benefits all segments of society, not just Medicare beneficiaries.

Today, I am introducing the All-Payer Graduate Medical Education Act of 2001 to create a fair and rational system for the support of graduate medical education—fair in the distribution of costs to all payers of medical care, and fair in the allocation of payments to hospitals. This bill establishes a Trust funded by a 1% fee on all private health insurance premiums. Teaching hospitals will see their direct and indirect GME payments increase by \$2.2 billion each year. In addition, because the current formula for direct GME is based on cost reports generated nearly twenty years ago, it unfairly rewards some hospitals and penalizes others. This bill replaces that outdated formula with an equitable, national system for direct GME payments based on actual resident wages.

Many critics of federal GME support fail to recognize its vast societal benefits. They have attacked indirect GME payments, complaining that hospitals are not required to account for their use of these funds. The All-Payer Graduate Medical Education Act provides a structured mechanism for hospitals to inform Congress and the public about their contributions to improved patient care, education, clinical research, and community services.

My bill also addresses the supply of physicians in the United States. Nearly every commission studying the physician workforce has recommended reducing the number of first-year residencies to 110% of American medical school graduates, down from the current level of 138%. This bill directs the Secretary of HHS, working with the medical community, to develop and implement a plan to accomplish this goal within five years.

This legislation will also ensure that hospitals are compensated fairly for the indigent patients they treat. Medicare disproportionate share (DSH) payments are particularly important to our safety-net hospitals. Many of these are in dire financial straits. This bill reallocates DSH payments, at no cost to the federal budget, to hospitals that carry the greatest burden of poor patients. Hospitals that treat Medicaid-eligible and indigent patients will be able to count these patients in applying for disproportionate share payments. This provision builds on changes made in last year's Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) to provide DSH payments equitably, regardless of the facility's location.

Finally, because graduate medical education encompasses the training of other health professionals, my bill directs \$300 million of the Medicare savings toward graduate training

programs for nurses and other allied health professionals each year. These funds are in addition to the current support Medicare provides for the nation's diploma nursing schools.

Numerous provider and patient groups have registered their support for the all-payer concept, including the Association of American Medical Colleges, the National Association of Children's Hospitals, the American Medical Student Association, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, the American Speech Language Hearing Association, the American Association of Colleges of Nursing, and the American Hospital Association.

I urge my colleagues to join me in protecting America's academic medical centers and the future of our physician workforce by supporting this legislation. Together, we can establish an equitable funding system for GME that ensures the continuation of the highest caliber medical workforce and patient care.

H.R. 2174: ROBERT S. WALKER AND GEORGE E. BROWN, JR., HYDROGEN FUTURE ACT OF 2001

**HON. KEN CALVERT**

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

*Thursday, June 14, 2001*

Mr. CALVERT. Mr. Speaker, I rise to introduce H.R. 2174, Robert S. Walker and George E. Brown, Jr. Hydrogen Future Act of 2001, a reauthorization of the Hydrogen Future Act of 1996.

I strongly support continued hydrogen research and development. While serving as Chairman of the Subcommittee on Energy and Environment of the Committee on Science I began consideration of this reauthorization, which has come to fruition today.

The President's National Energy Policy calls for a balanced energy supply portfolio—I completely support the President's recommendations. America's unprecedented economic growth and prosperity rests on an affordable supply of energy. And, we can all agree that reducing emissions and conserving resources is a good idea. For this reason, I continue to advocate the pursuit of greater efficiencies and reduced energy consumption in our industrial processes, in our transportation sector and in our communities and homes. The national energy strategy that will emerge from Congress and the Bush Administration will include all our energy options and hydrogen will have a place in that strategy. In fact, I am excited to report that the Bush Administration came out in support in my reauthorization bill today at the Science Committee's Subcommittee on Energy hearing today on "Hydrogen and Nuclear Energy R&D Legislation."

Mr. Speaker, I first became interested in the possibilities that hydrogen presents through my work with CD-CERT, an excellent engineering center at the University of California, Riverside—located within my 43rd Congressional district. CE-CERT is nationally renowned for initiating innovative programs to reduce energy demand and improve the environment. CE-CERT has successfully demonstrated a hydrogen vehicle, which has been well received. Additionally, Riverside County,